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The International Anti-Smoking Movement

ORGANIZATIONS AND INDIVIDUALS

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Of these organisations only the EEC has some legislative authority, but their combined influence is formidable, firstly in scientific circles, and latterly in the political arena.

This report is best seen as an initial effort to document the influence of the anti-smoking movement. The sources are all taken from published documents listed in the bibliographies. Inevitably the choice of people and organisations has been subjective, and other subjects for study will be doubtless be included in up-dates to the report.

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EXECUTIVE SUMMARY

Following adverse reports about smoking and health in the 1950s and 1960s the ANTI-SMOKING MOVEMENT began sporadically in disparate countries & regions. Early organisations involved at that time still operate.

From 1967 (First World Conference on Smoking and Health) anti-smoking began to take on an international dimension, beginning with Union Internationale Contre le Cancer (UICC) in 1969, followed by World Health Organization (WHO) in 1975. Up to the mid-1970s they were acting more or less independently.

Since 1980 more international organisations have taken up positions on tobacco. They include International Agency for Research on Cancer (IARC), the International Union for Health Education (IUHE), the International Union Against Tuberculosis (IUAT), the International Organization of Consumers Unions (IOCU) and the European Community (EEC). The speed of adoption of these positions has accelerated, and the positions themselves are more extreme and more intense. The activities undertaken include publishing, meetings, and (for WHO and EEC) debates & resolutions. Their initial public was scientific, but although their decisions & activities are not binding on anyone, their influence is bearing more and more on decision-makers & politicians either directly (e.g. via EEC Council of Ministers) or indirectly via pressure groups and national health associations.

Especially crucial is the fact that the international organisations are acting together against smoking, in organising joint meetings for example, and more especially by the cross-fertilisation produced by the contributions of the leaders of the movement - Nigel GRAY, Kjell BJARTVEIT, Lars RAMSTROEM, Mike DAUBE, Simon CHAPMAN and Roberto MASIRONI being the most prominent. Whichever organisation hosts an international forum, one or other of these people is bound to be present. In the context of collaboration, the International Liaison Committee (set up by UICC) is particularly important.

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HANDBOOK OF RESOLUTIONS AND DECISIONS OF THE WORLD HEALTH ASSEMBLY AND THE EXECUTIVE BOARD

Volume I
1948 - 1972

1st to 25th World Health Assemblies

1st to 50th sessions of the Executive Board

This cumulative edition of the Handbook, *which covers the first twenty-five World Health Assemblies and the first fifty sessions of the Executive Board, constitutes a definitive Volume I.*

WORLD HEALTH ORGANIZATION
GENEVA
1973

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June 1986

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Appendix 1

THE WORLD HEALTH ORGANIZATION

ORGANISATION & STRUCTURE

The WHO is a Specialised Agency of the United Nations, governed by an Executive Board of its member states, and the annual general meeting, the World Health Assembly.

There is a headquarters secretariat in Geneva plus six Regional Offices. A selective outline structure of some parts of the organisation follows, which is intended to situate the Smoking & Health Unit within the total organisation.

Policy is made by the World Health Assembly and the Executive Board, but there is contribution to the WHO's activities from individual countries through their own Regional Executive Committee and the Regional Office. According to specialised sources the WHO's total programme is the result of a very political process, even though the professionals and technical bureaucrats in the secretariat might prefer it otherwise.

FUNDING

The total expenditure for 1986/87 is estimated to be US$990,730,000. The sources of this money are follows:

1.	Member states	)
2.	'Occasional' receipts (e.g. Sales & Services)	) $554,000,000)
3.	United Nations (UNDP, UNICEF, UN Population program etc).	))
4.	Trust Funds	) $436,730,000
5.	Pan American Health Organization	)
6.	Miscellaneous and ad hoc grants	)

Over 60% of money from member states comes from the 'top 5', with the USA providing 25%. Large numbers of states pay around 1%, and the very poorest and smallest countries pay only 0.01% which is the minimum (Guinea, Albania, Malawi and Sri Lanka among others). Below are a few countries, for interest & comparison (All figures for 1986/87).

USA	25.00 %
USSR	10.35 %
Japan	10.13 %
W. Germany	8.38 %
France	6.39 %
U.K.	4.58 %
Italy	3.67 %
Canada	3.02 %
Brazil	1.36 %
E. Germany	1.36 %
Ukraine SSR	1.30 %
Sweden	1.30 %
India	0.35 %
Zimbabwe	0.02 %

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b) Commissioned Reports
Such as those on constituent levels in developing countries (FRECKER), methods of estimating "social cost" (FORBES & THOMPSON) and the geographic prevalence of smoking among young people (MASIRONI & ROY). The only one that has been issued in formal published format by WHO Sales Division is the report on legislation (ROEMER); the others tend to be circulated in the anti-smoking milieux, briefly reviewed or summarised in the medical or specialist press, but not widely publicised.

c) "Tobacco Alert"
Previously "Tobacco Report", this is a cheaply-produced 4-6 page A4 size round-up of anti-smoking trends, appearing quarterly and sent free to any interested parties. It is issued by Dr. Masironi's unit.

d) Press Releases & Wire Services
Issued whenever a situation can be highlighted or exploited; examples are meetings (e.g. smoking control seminar in Lusaka, Venice conference on smoking in the young), documents (Expert Committee reports), etc.

e) Reports on anti-smoking seminars

f) Guidelines for surveys (see bibliography)
For example, in February 1984 SHAHIDULLAH reported on smoking prevalence in Bangladesh, noting that "one of the objectives of the seminar was to test the applicability and use of the WHO standardised questionnaire for smoking habit assessment."

g) Educational Material
In collaboration with the International Union for Health Education, Dr. Masironi's unit is preparing material on anti-smoking health education for developing countries.

Financial Assistance

Some examples of funding by the WHO include support for applied research (e.g. smoking surveys); aid in establishing laboratories and training analytical scientists; help in establishing national anti-smoking campaigns & 'No-Smoking Days'; support in the founding of national Smoking and Health Associations; funding of experts to address seminars and meetings.

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The WHO cannot enforce action by member states, but is solidly anti-smoking and has a large 'establishment' role in the diffusion of a basic attitude to smoking and health, in movement away from tobacco growing, and in legislation at all levels (against advertising and smoking in public). The basic attitude is very extreme, as shown in their use of language, for instance - "controlling the smoking epidemic" "the removal of the hazard and not merely its marginal reduction .." "the fight against smoking on its own could contribute more to the improvement of health than any other measure", etc.

1986 REPORT & RESOLUTION (see Appendix 6)

A major step in the WHO's activity against smoking has been a report by the Director-General to the Programme Committee of the Executive Board (October 1985). Entitled "WHO Programme on Smoking & Health: the adverse health effects of tobacco use", the report is a major review of anti-tobacco activity internationally, together with proposals for future action, and a number of tables giving numerical data on consumption, incidence, mortality estimates etc.

At their meeting of 28/31 October, 1985, the Programme Committee examined this report, and made several amendments. It was considered by the Executive Board in January 1986, and a draft resolution prepared for the World Health Assembly in May 1986, as an Agenda item for the Assembly in plenary session. The resolution entirely condemns the active use of tobacco and its effect on non-smokers; deplores all attempts at promotion; urges member states to implement a radical 9-point programme without delay; requests support from other U.N. Agencies; requests the Director-General to implement a re-inforced anti-smoking programme without waiting for formal integration into the "Eighth General Programme of Work", and provides for increased funding up to US$350,000 p.a. During the debate six countries raised objections to the Resolution, proposing that it be deferred until adequate consideration had been given to the social and economic consequences. However, the Resolution was passed unanimously as it stood.

These moves represent a great intensification within the WHO of its opposition to smoking, and a harder push in the attempt to introduce restrictions on tobacco in all member states throughout the world.

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Appendix 1

STRUCTURE & FUNDING

Established in 1965 by the World Health Organization (WHA Resolution 18/44, Appendix 2), the IARC has a Governing Council (= a delegate from each participating state, plus Director-General of WHO) and a Scientific Council (12 eminent cancer scientists, appointed by Governing Council). IARC Director is Dr. Lorenzo Tomatis, with about 150 members of staff.

The membership, while theoretically open to any member state of WHO, is in fact quite strictly controlled by the Governing Council which has to decide if the candidate is in a position to contribute effectively to the work of the Agency. There are only twelve member countries at present (Canada, USA, Japan, Australia, Belgium, France, W. Germany, Italy, Netherlands, Sweden, UK, USSR).

The Agency is funded by the participating states, with dues based on their contributions to WHO plus grants & contracts. In 1983 the ordinary budget totalled $9,478,000.

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The texts of World Health Assembly resolutions strengthen over the years and it appears that the unit under Dr. Masironi dates from the 33rd WHA (1980) which requested the Director-General "to further develop an effective WHO action programme on smoking and health ..." and also "to mobilise financial and other resources for the implementation of the programme." However the funds and resources at Dr. Masironi's disposal have never been made clear until January 1986, and it is a subject he seems to avoid in his own writings.

Funding of WHO Programme on Smoking and Health

In a document circulated to the Executive Board in January 1986, the Director-General gave the following details of the funding of the Smoking and Health Programme ;-

US$ 150,000 were made available during 1984-1985 for basic staff and operational expenses, this sum coming from regular budget funds. In addition, a sum of US$ 134,000 was granted from the Director-General's Development Programme, and US$ 360,000 came from non-WHO budget funds.

For the biennium 1986-1987, funding from the same sources is expected to be US$ 200,000 (regular budget funds), US$ 134,000 (D-G Development Programme) and US$ 380,000 from extra-budgetary funds, to be used for a study on "social costs" of tobacco.

The Director-General estimated that to continue the present work on a long term basis, US$ 200,000 would be needed from regular Budget (biennially), and in addition US$ 500,000 from extra-budgetary sources.

ANTI-SMOKING ACTIVITIES

In his presentation to the Jakarta seminar (September 1984), Dr. Masironi outlined the activities undertaken by WHO to support their anti-smoking objectives. Below are some of the ways WHO activities do influence the anti-smoking scene, together with a few examples of actual situations. These examples are indicative only.

Publishing

Among the most important publicly available documents are

a) Expert Committee Reports
WHO has formally reported three times on smoking (see bibliography); the last report ("Smoking control strategies in developing countries") was widely publicised (see ANON World Tobacco, Multinational Monitor, Tabac & Santé) and is still often quoted when developing countries and tobacco are being discussed. It is very instructive to note the composition of these committees, which include many of the people who are renowned internationally for their anti-smoking stances, such as RAMSTROM (1975, 1979, 1983), MASIRONI (1975, 1979, 1983), DAUBE (1979, 1983), HORN (1975, 1979, 1983), LORANSKY (1975, 1979), GODBER (1975, 1979).

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Source: https://www.industrydocuments.ucsf.edu/docs/tsjl0000

In the most recent documents from the WHO (Director-General's Report and the Resolution adopted by the World Health Assembly in May 1986) and the EEC ('Europe Against Cancer') (1986), tobacco use is condemned in the most determined way, in language that admits no nuance or subtlety. The most obvious sign of the integration of the anti-smoking movement was the formation (1983) of the International Liaison Committee on Smoking and Health by the UICC, with Dr. Nigel Gray as Chairman.

Another crucial phenomenon has been the constant re-appearance of specific individuals on the anti-smoking scene. There has been cross-fertilisation of ideas and opinions between organisations because the same group of committed anti-smokers appears within the framework of these different organisations. Examples are BJARTVEIT (working for UICC, WHO and IUAT), GRAY (UICC, IARC), RAMSTROEM (WHO,UICC), and MASIRONI (WHO and IUAT). Moreover, meetings or workshops will often be organised jointly, especially by UICC and WHO, and latterly in Penang (Malaysia), by UICC and IOCU.

It is interesting to note that of the six 'leaders' whose careers are outlined here five are from Anglo-Saxon/Scandinavian cultures. Dr. Nigel GRAY is Australian, Simon CHAPMAN also, Mike DAUBE is British, Lars RAMSTROEM Swedish, and Kjell BJARTVEIT Norwegian. The movement contains a number of people who have been convinced anti-smokers for twenty years or more, BJARTVEIT and RAMSTROEM for instance, (see also 'Anti-smokers of long standing' Appendix 1). All these people have worked as colleagues on the same reports, in committees, at workshops, on campaigns etc. (see Appendix 2)

The kinds of activity that can be done by these people and organisations are

- publications; for example
  experts' reports (e.g. "Controlling the smoking epidemic", WHO 1979)
  monographs ("Legislative action to combat the world smoking epidemic", 1982)
  bulletins & activist guides ("Guidelines on smoking control" 2nd ed. 1980 UICC) ("The Lung Goodbye" 1983 IOCU)
  surveys ("Actions against smoking in the member states of the European Community")
  (EEC 1983)

- meetings; for example
  UICC Smoking Control Workshops: several per year, various countries
  WHO International Seminars on Smoking & Health (see WHO entry)

- debates; The EEC and WHO are uniquely placed to put forward resolutions in their debating bodies, which ultimately polarise opinion around the issue and bring pressure to bear on their constituent Member States.

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Source: https://www.industrydocuments.ucsf.edu/docs/fsj0000

INTRODUCTION and OVERVIEW

It was the general consensus of observers that with the Fifth World Conference on Smoking and Health (July 1983), the anti-smoking movement had come of age, and this present report has been assembled to document the increasing collaboration in the international anti-smoking movement over the past few years. Despite numerous influential national reports (the U.S. Surgeon General at intervals from 1964, the Royal College of Physicians at intervals, many individual studies and papers), smoking issues only became really international in 1975 with the first World Health Organization report "Smoking and its effect on health" (TR 568). The political agitation about tobacco, until quite recently, has been limited to disparate units operating on their own territory.

These national bodies still exist, and are still pursuing their anti-smoking aims. They include, as examples, The Health Education Council (UK), Health Education Bureau (Eire), National Interagency on Smoking & Health (USA), and National Council on Smoking & Health (Norway). These government bodies are aided and abetted by pressure groups such as Action on Smoking & Health (UK & USA), Group Against Smoking Pollution (USA), Conseil National Contre le Tabagisme (France) and BUGA-UP (Australia). They implement, within their limits and at the local level, the resolutions and decisions of a number of international organisations which took up anti-smoking positions in the 1970s. The aim of this report is to describe these international organisations, and demonstrate how the anti-smoking movement is becoming an integrated and unified operation, even though there is not one single international anti-smoking organisation.

World Conferences have been held regularly, (New York 1967; London 1971; New York 1975; Stockholm 1979; Winnipeg 1983; Japan planned for 1987), but the first international document was from the Union Internationale Contre le Cancer ("Influencing smoking behaviour" 1969). The UICC have continued their publishing, and were joined by the highly influential World Health Organization (WHO) with the report already quoted (1975). About 1979, the European Economic Community (EEC) and its constituent parts began taking an active interest, and other bodies studied - the International Agency for Research on Cancer (IARC), the International Union for Health Education (IUHE), the International Organization of Consumers Unions (IOCU) - all began activity in the 1980s.

One of the most remarkable aspects of this evolution has been the speed with which intense stances have been adopted by these bodies. Beginning with references in passing to tobacco at its 1981 General Assembly, the IOCU in five years developed a full-scale programme against tobacco promotion. At only its second Smoking & Health Committee meeting (1983) the IUAT already began co-operating with the WHO, preparing a briefing paper on tobacco for its members, and planning a smoking survey among medical students. From having no position on smoking since its formation (1951) the IUHE published a complete anti-smoking edition of its journal "Hygie" (March 1983), and elected as President in 1985 Dr. Harry Crawley, Director of the Health Education Bureau (Eire) and an active anti-smoker.

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Source: https://www.industrydocuments.ucsf.edu/docs/tsjl0000

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Source: https://www.industrydocuments.ucsf.edu/docs/tsjl0000

HANDBOOK OF RESOLUTIONS AND DECISIONS OF THE WORLD HEALTH ASSEMBLY AND THE EXECUTIVE BOARD

Volume II

Fifth edition

(1973-1982)

26th to 35th World Health Assemblies

51st to 70th sessions of the Executive Board

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WORLD HEALTH ORGANIZATION
GENEVA
1983

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Influence

The influence of the UICC in the world at large is very considerable. The Union has consultative status with WHO and ECOSOC, and is clearly highly regarded by cancer professionals throughout the world. The Smoking & Health Programme is undertaken by people who are known to be committed activists, and the manuals are used & quoted throughout the world anti-smoking community. The workshops are thought to be highly influential by the Union itself, both in focussing attention on the situation and in stimulating further action in the country or region. The meeting on smoking control organised by the UICC in 1976 with Dr. Gray as Chairman was a turning point in the Union's commitment against smoking. The World Conferences apart, it is the only time that the five 'elder statesmen' of the anti tobacco movement have met together in one place. The UICC's leadership role has continued with their sponsorship of the International Liaison Committee (1983 onwards). It is therefore absolutely certain that the anti-smoking community without UICC would lack the penetration and force that make smoking issues so acute.

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Source: https://www.industrydocuments.ucsf.edu/docs/tsjl0000

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id. "Global Medium-Term Programme. Programme 13.17 Smoking and Health", WHO, (September 1983) NCD(SMO)/MTP/83.1, 9p.

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WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR EUROPE

WELTGESUNDHEITSORGANISATION
REGIONALBÜRO FÜR EUROPA

ORGANISATION MONDIALE DE LA SANTÉ
BUREAU RÉGIONAL DE L'EUROPE

ВСЕМИРНАЯ ОРГАНИЗАЦИЯ ЗДРАВООХРАНЕНИЯ
ЕВРОПЕЙСКОЕ РЕГИОНАЛЬНОЕ БЮРО

EUR/RC34/7 Rev.1
6388D/6389D
21 December 1984
ORIGINAL: ENGLISH

REGIONAL TARGETS IN SUPPORT OF THE REGIONAL STRATEGY FOR HEALTH FOR ALL

At its thirtieth session in Fez in 1980, the Regional Committee requested that specific regional targets be formulated to support the implementation of the European regional strategy for attaining health for all (HFA) by the year 2000. It was felt that such targets would motivate Member States to get actively involved in reaching the health for all goal. The present document formulated these regional targets, which suggests levels of improvement required in the health of the population, as well as ways of achieving them.

The present document was endorsed by the Regional Committee at its thirty-fourth session in September 1984.

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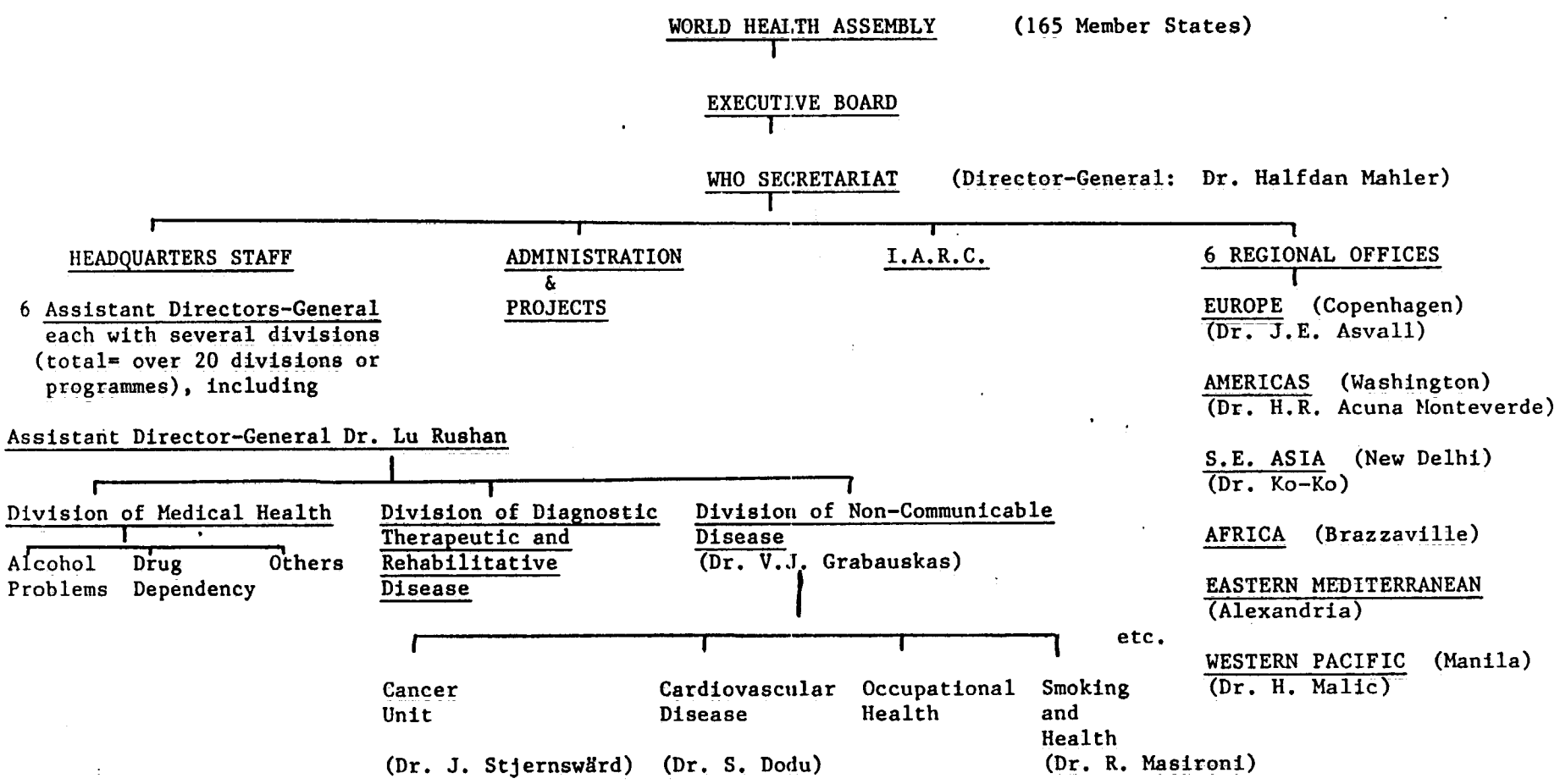

Total number of bureaux, services or units (excluding HQ Administration) = 112
of which Smoking and Health is one.

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Source: https://www.industrydocuments.ucsf.edu/docs/tsjl0000

WORLD HEALTH ORGANIZATION	Regional Office for Europe. "Regional targets in support of the regional strategy for health for all", Regional Office, (December 1984), EUR/RC 34/7 Rev.1, 77p.
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INTERNATIONAL AGENCY FOR RESEARCH ON CANCER (IARC)

Established by the World Health Organization in 1965, the Agency was designed to be a service in cancer research per se, and an international resource. The programme comprises:

a. Development and execution of specific research programmes
b. Scientific evaluation of available data
c. Education and information

The research part of IARC operations is handled in their own building in Lyon, or more generally contracted out to scientists working on particular problems; this is specially true of the epidemiological and multi-disciplinary studies, such as the maintenance of large cancer registries, and long-term studies of cancer in particular sites.

The Education/Information function is undertaken with a large scientific publishing programme, and series of meetings or symposia, as well as courses and scholarships.

SMOKING

Up to November 1984, the IARC had not concentrated formally on smoking per se, but with the number of allegations about tobacco & cancer the Agency would clearly not ignore the topic either. The 1980 Annual Report has this to say about lifestyle and cancer prevention:

> "... there is growing evidence that the public will modify lifestyle habits if convinced that such a change will be of value to health. This is demonstrated by the very considerable changes in cigarette consumption in certain population groups in many countries ...."

In 1979 the Agency issued symposium proceedings (jointly with the French research body INSERM) on preventing cancer risk (DAVIS) in which there were descriptions of the anti-tobacco legislation in France (DENOIX) and Finland (ELO). This departure into the legal/political domain was somewhat unusual for the Agency, whose publishing is usually scrupulously technical/scientific in content and tone. Typical work on tobacco in this context is the chemical work on volatile nitrosamines (BRUNNEMAN) and the analyses of tobacco smoke in the 'Environmental carcinogens' series (PREUSSMAN).

However, in the 1983 Annual Report the Director notes:

> "The IARC envisages that two future volumes in this series (Environmental Carcinogens) will deal with the evaluation of carcinogenic risks linked to two widespread cultural habits: the chewing of betel nut, and the use of tobacco."
> (uncertified translation)

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INTERNATIONAL UNION FOR HEALTH EDUCATION (IUHE)

The Union is an organisation of national governmental bodies & individuals whose focus is on the promotion of education about health among the general public.

SMOKING

The IUHE was included in this report chiefly because of the issue of "Hygie" for March 1983, which was mainly taken up with anti-tobacco articles. While it is true that smoking is not a major focus at the moment, smoking issues certainly do feature on the priorities of some constituent members (notably the UK Health Education Council and the Irish Health Education Bureau), and the Union is a forum where committed anti-smokers could expect to be heard sympathetically. The Union's quarterly journal regularly includes anti-smoking news, in its 'health education' aspect, as the following examples show:

"Glasgow to become a non-smoking city" (March 1984)

"Recommendations of the Fifth World Conference on Smoking and Health" (a major review, June 1984).

"Smoking: highest priority for the HEC" (June 1984)

"The Brigantia smoking survey" (major article by Anne CHARLTON, September 1984)

"Guidelines on smoking cessation" (Book review, March 1985).

Smoking issues also featured at the Dublin World Conference (September 1985). It is worth noting that Dr. Harry Crawley, the Conference Director has just been elected President of the IUHE, and is the Director of the Health Education Bureau in Ireland. He is a leading Irish anti-smoker, who at the conference presented a paper on his own anti-tobacco campaign "Knot in Public". Otherwise at the meeting, out of 354 papers 29 were on smoking issues, some poster presentations, and six anti-smoking videos.

The Union has consultative status with ECOSOC, UNESCO, WHO and UNICEF. WHO and UNICEF helped sponsor the Dublin conference; WHO and UNESCO send observers to the Technical Development Board. Thus the IUHE is a very credible body of health education professionals, and though they are not mounting a major campaign (compared to UICC, for example) the Union is collaborating closely with the WHO Smoking & Health programme to produce educational material for developing countries (MASIRONI).

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Source: https://www.industrydocuments.ucsf.edu/docs/tsjl0000

WORLD HEALTH ORGANIZATION (WHO)

The WHO is a Specialised Agency of the United Nations, with 165 member States, governed by an Executive Board (twice-yearly) and the annual meeting, called the World Health Assembly. The Assembly is attended by senior politicians (normally Health Ministers) and senior medical personel from each member State.

The very abbreviated organisation chart and the budget figures (Appendix 1) give some idea of the vast scale of WHO's operations; the immense range of its health-related interests can be seen from the contents-list of its publications catalogue (Appendix 5) and its organisational divisions (Appendix 2). The WHO charter gives its first objective as "the attainment by all peoples of the highest possible level of health", a goal given practical expression by the Alma-Ata declaration of 1978 and all the planning and other activity supporting the impetus of "Health for All by the Year 2000".

SMOKING

Within the total operation, the WHO's commitment against tobacco has been expressed in various documents:

1. Most recently, the Resolution passed unanimously by the World Health Assembly in May 1986, and the Director-General's Report on which it was based. (See Appendix 6)

2. World Health Assembly decisions & resolutions (Texts given in Appendix 3).

3. Documents emanating from the Regional Offices, especially the European Office in Copenhagen (see "Regional targets in support of regional strategy for Health for All", Appendix 4).

4. Reports from Expert Committees (see bibliography).

5. Internal policy documents (see bibliography).

6. Proposed Programme Budget 1986/87. Issued in 1984, this planning document contains a serious position statement of WHO's view of smoking, and its implications for health and economics. Translated from the French version (only one available at time of writing), it is quoted in extenso:-

"The use of tobacco is the most widespread risk factor in the aetiology of lung cancer, cardiovascular diseases, and other disorders covered by this programme. An estimate of the number of premature and avoidable deaths due to tobacco use would be higher than 500,000 in Europe alone, while in the USA over 300,000 deaths per year result from tobacco use. The WHO Expert Committee on Smoking Control Strategies in Developing Countries which met in 1982 confirmed that the number of premature or avoidable deaths resulting from tobacco greatly exceeded 1 million per year, even according to the most cautious estimates.

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Source: https://www.industrydocuments.ucsf.edu/docs/tsjl0000

IUHE Bibliography

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IUHE "Abstracts. 12th World Conference on Health Education, Dublin, September 1985"

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YEARBOOK OF INTERNATIONAL ORGANISATIONS "International Union for Health Education" Entry B2659, U.I.A., (1983/4), 1p.

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Source: https://www.industrydocuments.ucsf.edu/docs/tsjl0000

Meetings

Another highly visible means of concentrating attention is the series of seminars and conferences on smoking control (often sponsored jointly) each with its own attendant publicity, published proceedings, and political influence. Many of these meetings have been funded by special grants from the Swedish Development Agency. Some examples follow:

1. International Conference on Tobacco and Youth, Venice, (November 1981).

2. Fifth International Symposium on Prevention & Detection of Cancer, Sao Paulo (May 1982)

3. Tobacco & Cancer: New investigational approaches, Brussels (March 1983)

4. Effects of Indoor Air Pollution, with special reference to nitrogen oxides & smoking, Lyngby (January 1984)

5. Workshop on Smoking & Health, Suzdal, USSR, (September 1983)

6. Symposium on Smoking & Health in the South European Countries, Barcelona, (March 1984)

7. National Seminar on Smoking & Health, Dhaka (February 1984)

8. International Seminar on Smoking & Health, Lusaka (June 1984)

9. Seminar on Smoking & Health, Jakarta (September 1984)

10. Workshop on Smoking & Health, Khartoum (November 1984)

11. Smoking Control Workshop, Buenos Aires, (November 1985)

The WHO has taken a role in all the World Conferences, including the Fifth World Conference on Smoking & Health (Winnipeg, July 1983). However, despite preparing an address, the Director-General declined at the last moment to appear personally at the conference, and his speech was read by Dr. Masironi, who, with Dr. Al-Awadi (from Kuwait, and chairman of the latest Expert Committee) was the sole representative of the Organization at Winnipeg. An article speculating on Dr. Mahler's non-appearance was published in 'The Health Services' (TURNER). The absence of a high WHO profile at such a key meeting is in accord with an observer's opinion after the 1985 World Health Assembly, which gave the view that WHO bureaucrats are not very comfortable with radical interventionist positions since they have to answer to a controlling body representing governments with widely varying political stances.

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Source: https://www.industrydocuments.ucsf.edu/docs/tsjl0000

INFLUENCE ON HEALTH POLITICS AND ON PUBLIC OPINION

The prestige of WHO is such that it can be quoted with very great credibility in a wide variety of situations, of which the most important are those where legislative decisions are being taken. An indicative sample of situations is given below, to demonstrate how WHO attitudes are used in political circumstances throughout the world.

- CANADA "The Task Force supports the WHO position that there should be total prohibition of all forms of tobacco promotion in all countries" (ONTARIO COUNCIL OF HEALTH).

- JAPAN "The 1975 WHO recommendations include restriction on tobacco advertisements. What is the government's view on the recommendation, and specifically what steps has it taken in response to it?" (KUSAKAWA).

- UNITED KINGDOM "Mr. Pavitt asked the Secretary of State for Social Services if he will seek at the World Health Assembly to stem the advertising and promotion of cigarettes and tobacco products in developing countries" (PAVITT).

- KENYA "Kenya has banned all smoking in public places in response to WHO's recently launched campaign ... " (ANON - World Health 1980).

- GULF STATES "This anti-tobacco campaign should constantly keep an eye on the following: (among others) - To maintain a liaison with other international health organisations, especially WHO and UICC ..." (EL RAHMAN).
"Health Ministers ... have closely followed the guidelines laid down by WHO which include a complete ban on tobacco advertising and promotion" (ANON - Arab Times).

- SOCIALIST COUNTRIES "The broad international collaboration contained in this symposium is very definitely the kind of positive development that is being looked for and promoted by WHO" (RAMSTROM). "It was also hoped that the meeting (at Suzdal) would provide WHO with a network of contacts in socialist countries that could be of value for future activities in the smoking and health programme" (ANON - WHO Chronicle).

- GHANA, KENYA, MALAYSIA, THAILAND "In table 16/1 the policies in the four studied countries are compared to the WHO recommendations concerning cigarette production, distribution and consumption" (WICKSTROM).

- DEVELOPING COUNTRIES "After reading ... 'Smoking Control Strategies in Developing Countries', one cannot help seeing a certain parallel between the opium trade of the Victorians and the promotion of tobacco smoking in the Third World today". (ANON. South African Medical Journal).

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Source: https://www.industrydocuments.ucsf.edu/docs/tsjl0000

It cannot be an accident that the Chairman of the IARC Scientific Council at its 19th Session (January 1983) was Dr. Nigel Gray, of the Victorian Anti-Cancer Council, and the UICC.

In October 1984 and February 1985 the Agency convened closed meetings on tobacco, inviting experts from around the world. The proceedings of each meeting are planned for publication, but only the first (on the tobacco habit apart from smoking) has appeared as at March 1986. However, there is reason to believe that drafts of the volume on smoking tobacco have been circulated among the anti-smoking milieux, since it has been quoted by BJARTVEIT and by the U.S. Office of Technology Assessment.

Like its parent body the WHO, the Agency's influence is transmitted because of its leadership role in its field. Mammoth compilations such as "Cancer incidence in five continents" (WATERHOUSE) could scarcely have been issued without a body like IARC, and its function as a centre of attention and of information exchange means that everyone involved in cancer research has the Agency as a focus. During 1983 alone, the following people, all known for positions about smoking, visited Lyon, as members of working groups, or in other capacities:

> J.E. Asvall (now Director, WHO Europe), A. Englund (then Executive Director UICC), V.I. Grabauskas (Masironi's superior at WHO), T. Hirayama, D. Hoffmann (associate of Wynder at American Health Foundation), H. Mahler (DG, WHO), R. Masironi, R. Peto, and D. Trichopoulos.

It is very likely that the proceedings now in preparation by IARC will be one of many documents providing for WHO the alleged scientific support for yet more forceful efforts to eradicate smoking.

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Source: https://www.industrydocuments.ucsf.edu/docs/tsjl0000

ACTIVITIES

The Union's work is organised into eleven programmes, listed below, with the Chairman of each Programme Committee.

1.	Tumour Biology Programme	(Dr. M. Burger)
2.	C I C A Programme	(Dr. R.L. Clark)
3.	Professional Education Programme	(Dr. S. Eckhardt)
4.	Treatment and Rehabilitation Programme	(Dr. I. Elsebai)
5.	Smoking and Cancer Programme	(Dr. N. Gray)
6.	Multidisciplinary Project on Breast Cancer	(Mr. J. Hayward)
7.	Epidemiology & Prevention Programme	(Dr. T. Hirayama)
8.	Fellowships & Personnel Exchange	(Prof.L.G.Lajtha)
9.	Multidisciplinary Project on Oral Cancer	(Dr.J.J.Pindborg)
10.	Detection & Diagnosis Programme	(Dr. U. Veronesi)
11.	Campaign Organisation & Public Education	(Judge J.H.Young)

Clearly the orientation of the Union is highly technical, clinical and professional. Indeed, only programmes 5 and 11 (and perhaps 7) have an impact on the general public, which is confirmed when one seeks documentary evidence for the influence of the UICC on legislative decisions for instance. There is little mention of the organisation in the popular press, and its work is largely limited to co-operation among cancer professionals. This is also reflected in its publishing programme, which consists of the following:

Periodicals:

- "International Journal of Cancer" (serious articles on cancer in all aspects).
- "International Cancer News" (News bulletin for general public).
- Calendar of meetings on cancer.

Monographs:

- Technical Report series
- Directories (of research for example)
- Conference proceedings and reports.

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Source: https://www.industrydocuments.ucsf.edu/docs/tsjl0000

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Appendix 1

ORGANISATION and STRUCTURE

Founded in 1934, the UICC was set up as an international centre to promote the fight against cancer. Its objectives are

a. To form or support national cancer societies
b. To promote public education about cancer
c. To act as an international clearing-house for the exchange of information (via meetings and publications) and of personnel (via fellowships and exchange-visits).

The Union has 178 members in 76 countries made up of

a. Voluntary national associations, (like the American Cancer Society)
b. Cancer research bodies (e.g. Imperial Cancer Research Fund)
c. Government bodies (e.g. Madras Cancer Institute)

plus associate members such as bodies with cancer as a peripheral interest, or organisations not directed by medical personnel.

The governing structure of the Union is as follows:

GENERAL ASSEMBLY (3 delegates (max) from each country)
(meets every 4 years).

COUNCIL (15 members of the General Assembly,
+ 7 Vice Presidents
+ Executive Committee)
(meets every 2 years).

EXECUTIVE COMMITTEE (15 members, including chairman of some programmes)
(Annual)

SECRETARIAT
Executive Director: Dr. Philip Selby
14 paid members of staff (1983).

FUNDING

- Membership Dues (vary by country from $500 to $60,000)
- Special Grants & Contributions.

Budget (1983) US$1,300,000.

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Source: https://www.industrydocuments.ucsf.edu/docs/tsjl0000

ACTIVITIES

Founded in 1951, the Union's objectives are:

a. To pool experience and knowledge of health education between people and organisations
b. To promote scientific research in health education
c. To improve professional preparation, education & training in the speciality
d. To encourage the development of informed public opinion on health living.

There are standing committees on study & research, and professional preparation, plus a Technical Development Board (32 members + observers) of health education 'experts in the field'.

The Union organises:

Meetings

World Conferences, Regional Conferences (notably the Triennial conference and General Assembly; 1982 Hobart, 1985 Dublin)

Seminars and Symposia (e.g. "Health education in primary health care", Geneva, May 1984)

and publicises meetings in its domain where it is not directly implicated.

Publications

"Hygie: International Journal of Health Education" quarterly
Secretariat Bulletin

European monographs on research in health education (actually issued by constituent members in Scotland, France and W. Germany)

Conference proceedings

"Europe News" (from the Köln regional office)

Languages are English or French or Spanish, with summaries in the languages not used principally.

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Appendix 1

STRUCTURE and ORGANISATION

Founded in 1951, the IUHE is an organisation designed to promote professional health education at the international level. Its governing structure is as follows:

GENERAL ASSEMBLY (meets every 3 years. All members)

EXECUTIVE COMMITTEE(20 elected members, 12 Permanent Counsellors, Unions Officials)

SECRETARIAT (Paris)

President: Dr. Harry Crawley

Secretary General: Dr.E. Berthet

Executive Director:
(in day-to-day change)
Mr. D. Sigaudès
2 paid staff, some volunteers.

REGIONAL OFFICES

Europe (Köln) Prof. M.A. Modolo

Africa (Lagos) Dr.J.Laoye

N.America(Ottawa) Dr.F.Fiori

N.W.Pacific(Seoul)Prof.Y. Kanenaga

S.E. Asia Dr. V. Ramakrisha

Three further Regional Offices are being considered: Latin America, Eastern Mediterranean, and S.W. Pacific.

There are three classes of membership:

a) Constituent Members (National organisations whose sole purpose is health education) (22 countries).

b) Group Members (with health education as a peripheral or subsidiary interest) (24 countries)

c) Individual members (71 countries).

FUNDING

a. Membership dues

b. Sales

c. Grants & Gifts

No figures are available.

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Source: https://www.industrydocuments.ucsf.edu/docs/tsjl0000

FOOD AND AGRICULTURE ORGANIZATION — "The economic significance of tobacco" FAO (1983) ESC:Misc 83/1 50p.

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FRECKER, R.C and PISCHKITL, H. — "Constituents of cigarettes from developing countries ..." WHO, (1984) WHO/SMO/84.4

KUSAKAWA, S. — "Tenor of a question concerning tobacco sales policy" Japan. House of Representatives, (July 31, 1982), 4p.

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Source: https://www.industrydocuments.ucsf.edu/docs/tsjl0000

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GRAY, N.	"Special Project on Smoking and Cancer" UICC Bulletin (August 1982) 20:(3) Activities Report 1980-1982, 2pp.
GRAY, N.	"Lung Cancer Prevention: why, where and how the UICC has tried to assist this political and cultural process" Proceedings 13th Int. Cancer Congress (September 8-15), 1982) Abstract 3723, p.652
GRAY, N.	"Smoking and Cancer Programme" UICC News, (September 1984) 2:(3/4) p.33-35
GRAY, N. and DAUBE, M.	"Guidelines for Smoking Control" 2nd ed., UICC, (1980), Technical Report 52, 134p. Appendices (also available in Spanish and German)
HOBBS, P.	"Public Education about Cancer: recent research and current programmes" UICC, (1984), Technical Report 77, 104pp. (Includes papers on smoking by CHARLTON, JOTTI, and DOELLNER).
KUNZE, M. and WOOD, M.	"Guidelines on Smoking Cessation", UICC, (1984), Technical Report 79, 74p.
UICC	"International Catalogue of Films, Filmstrips and Slides on Public Education about Cancer" UICC, (1980), Technical Report 54, 186p. (80 pages on Smoking visual aids).
WAKE, R. et al	"A Manual on Smoking and Children" UICC, (1982), Technical Report 73, 127p.
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ELO, O.	"Anti-smoking legislation in Finland" in DAVIS, W. op.cit. pp.21-40
INTERNATIONAL AGENCY FOR RESEARCH ON CANCER	"Annual Report 1980" IARC, (1980), 202pp.
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PREUSSMAN, R.	"Environmental carcinogens: selected methods of analysis. Vol.6 n-nitroso compounds, IARC, (1983), 508pp.
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YEARBOOK OF INTERNATIONAL ORGANISATIONS	"International Agency for Research on Cancer" Entry E 3549 (1983/84) 1p.

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"Apart from premature death, enormous numbers of debilitating illnesses, resulting in vast health care costs, and in production losses from absenteeism, can also be imputed to the use of tobacco. It is estimated that one-third of all cancer cases, 80% of lung cancer cases, 75% of chronic bronchitis, and 25% of myocardial infarct are due to cigarette smoking. The Expert Committees recently convened have all underlined that the diseases linked to smoking are responsible for such a rate of incapacity and premature death in the industrialised world, that just on its own the fight against tobacco could be the greatest single contributing factor to the improvement of health and the prolongation of life in those countries.

"In the majority of industrial countries the public health authorities have more or less complete anti-smoking programmes in force; the expansion of the tobacco industry has been restrained to a certain extent by legislation and voluntary agreement, as well as by the increasing awareness of the dangers of smoking on the part of the general population. On the other hand, in most developing countries, commercial and other considerations have made the production, sale, and consumption of tobacco more difficult to control.

"Most industrial countries have managed to halt the increase of smoking incidence. In some, this latter has definitely diminished, above all in middle aged and educated men, but also in young people. By contrast smoking prevalence continues to increase in women though at a slower rate than in previous years.

"In most developing countries, the use of tobacco is expanding more and more. In some, like Nepal or Papua-New Guinea and several Latin American countries, smoking prevalence is as high as in industrial countries, or even higher. In the Arab Gulf states smoking incidence is rapidly increasing. In other Third World countries like India or Bangladesh the smoking of Western-type cigarettes is infrequent, but traditional modes of tobacco use, like the bidi or hookah, are widespread and provoke oral cancer or chronic respiratory disease, to levels never attained in Western countries. Bad housing, unhygienic environments, malnutrition, the absence of legislation against smoking, and the lack of information on the dangers of tobacco expose the peoples of underdeveloped countries to future epidemics of diseases linked to smoking."

Dr. Masironi is Co-ordinator of the Programme on Smoking and Health, (since about 1980) now a separate entity within the Division of Non-Communicable Diseases (NCD), but previously an adjunct of the Cardiovascular Disease Unit. His brief has implications for other programmes, notably cancer, cardiovascular disease, respiratory disease, oral health, occupational health etc. all of which have objectives and funds of their own. One result of this cross-classification is that 'Smoking and Health' is always well-integrated in the activities of these other programmes, especially publishing.

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Appendix 6

RESOLUTIONS OF THE EXECUTIVE BOARD OF THE WHO
RÉSOLUTIONS DU CONSEIL EXÉCUTIF DE L'OMS
РЕЗОЛЮЦИИ ИСПОЛНИТЕЛЬНОГО КОМИТЕТА ВОЗ
RESOLUCIONES DEL CONSEJO EJECUTIVO DE LA OMS

Seventy-seventh Session

EB77.R5

Agenda item 15

16 January 1986

TOBACCO OR HEALTH

The Executive Board,

Having considered the report by the Director-General on tobacco or health;[1]

Believing that the Organization must reiterate its clear and firm policy on tobacco versus health;

RECOMMENDS that the Thirty-ninth World Health Assembly adopt the following resolution:

The Thirty-ninth World Health Assembly,

Recalling resolutions WHA31.56 and WHA33.35 on the health hazards of tobacco and the WHO action programme against tobacco use;

Deeply concerned by the current pandemic of smoking and other forms of tobacco use, which results in the loss of life of at least one million human beings every year and in illness and suffering for many more;

Believing that the battle between health and tobacco must and can be won for the sake of human health;

Encouraged by the existence of total bans, restrictions or limitations on tobacco advertising in several countries;

1. AFFIRMS:

(1) that tobacco smoking and the use of tobacco in all its forms is incompatible with the attainment of health for all by the year 2000;

(2) that the presence of carcinogens and other toxic substances in tobacco smoke and other tobacco products is a known fact; and that the causal link between tobacco and a range of fatal and disabling diseases has been scientifically proven;

(3) that passive, enforced or involuntary smoking violates the right to health of non-smokers, who must be protected against this noxious form of environmental pollution;

2. CALLS for a global public health approach and action now to combat the tobacco pandemic;

3. DEPLORES all direct and indirect practices the aim of which is to promote the use of tobacco, as this product is addictive and dangerous even when used as promoted;

4. URGES those Member States which have not yet done so to implement smoking control strategies; these, as a minimum, should contain the following:

(1) measures to ensure that non-smokers receive effective protection, to which they are entitled, from involuntary exposure to tobacco smoke, in enclosed public places, restaurants, transport, and places of work and entertainment;

[1] Document EB77/22 Add.1.

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Source: https://www.industrydocuments.ucsf.edu/docs/tsjl0000

UNION INTERNATIONALE CONTRE le CANCER (UICC)

As the centre of an international network of organisations interested in cancer, the UICC has a very sharp focus on the disease, its prevention & control. Although the Secretariat is quite small, the Smoking & Cancer Programme is one out of only 11 areas, (see appendix 1) and can command a lot of attention from the leaders. Thus those working under its aegis are very clearly committed to the eradication of cancer, and tobacco is a target given a lot of attention. Its public is normally cancer specialists, and although its anti-smoking publications all carry a note of urgency, the normal method of working in this area, as in others, is through prominent national individuals & organisations, and through local health professionals, rather than in direct political agitation. Particularly prominent are the UICC regional meetings and workshops.

SMOKING

The Smoking and Cancer Special Project (now Programme) began in 1975 by means of a special grant of $50,000 from the International Cancer Foundation. Like Masironi's Unit in WHO, it crosses the structural divisions of the organisation (e.g. with implications for programmes 3, 7, 9, 10, and 11) and this is why (along with financial reasons) it only became a full Programme in 1982. Dr. Gray also makes it clear that the 1976 workshop of which he was Chairman produced policy objectives that were later accepted by both WHO and IUAT, providing "the basis for an internationally uniform set of goals." (GRAY 1981)

Apparently the Smoking & Cancer Programme has always had to rely on special grants rather than being integrated into the main budget; the Programme has been funded since 1981 by the Norwegian Government ($50,000 per year). The UICC is the centre, through this programme, of the INTERNATIONAL ANTI-SMOKING LIAISON COMMITTEE, (Chairman: Dr. D. Nostbakken), consisting of representatives of WHO, IUAT, IUHE, ISFC, and of the countries organising the World Conferences on Smoking & Health (UK, USA, Sweden, & Canada).

The Programme includes a number of consultants, each responsible for smoking control activities in particular regions:

Asia	-	Dr. Nigel Gray
Europe	-	Dr. Michael Kunze
	-	Mr. Michael Daube
China		Dr. Kjell Bjartveit
India	-	Mr. D. Simpson
South America	-	Mr. Allan Erickson
Africa	-	Mr. Michael Daube.

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Source: https://www.industrydocuments.ucsf.edu/docs/tsjl0000

Finally, there must be planned, systematic monitoring and evaluation of the public acceptability and relative success of health education programmes to provide feedback to increase their relevance and effectiveness. Accordingly, health education must also be adequately integrated into academic structures.

3.2 Promoting healthy behaviour

3.2.1 Positive health behaviour

Target 16 BY 1995, IN ALL MEMBER STATES, THERE SHOULD BE SIGNIFICANT INCREASES IN POSITIVE HEALTH BEHAVIOUR, SUCH AS BALANCED NUTRITION, NONSMOKING, APPROPRIATE PHYSICAL ACTIVITY AND GOOD STRESS MANAGEMENT.

This could be achieved if clear targets in these areas are set in each Member State, e.g. a minimum of 80% of the population as nonsmokers and a 50% reduction in national tobacco consumption - and if steps were taken by WHO and other international organizations to promote cooperation in health promotion activities throughout the Region in order to make a wider impact on basic health values.

Problem statement

Positive health behaviour constitutes a conscious effort by individuals to actively maintain their health and that of others. Research indicates that practices such as eating a balanced diet, taking regular physical exercise, ensuring rest and relaxation and engaging in rewarding social and sexual relationships help to increase an individual sense of wellbeing and act as a buffer against illness.

Most research hitherto has focused on health-damaging rather than health-enhancing forms of behaviour, but the interest in developing positive health indicators is growing. In a number of Member States, health education programmes have begun to promote health as an important cultural value. In some countries, a new interest in health is manifest among the general public. Physical activity, sports, health foods, stress relief, meditation and nonsmoking are not only gaining individual attention but also constitute part of a value change promoted by groups of environmentalists and ecologists within the Region.

Positive health behaviour is by far the most challenging field for a health promotion policy. It opens up important fields of research, since more knowledge is needed of what constitutes positive health behaviour and how individuals can be induced to take more responsibility for their own health and for that of others.

As regards balanced diet, health-damaging nutrition problems include insufficient food, unbalanced nutrition, overnutrition and self-imposed undernutrition. The problem of insufficient food is related to social equity and sufficient basic resources, problems discussed as prerequisites to health. Unbalanced nutrition may be due to lack of knowledge, but is closely related to food advertising, packaging, etc., as well as to the choice of menus in fast-food outlets, cafeterias and restaurants. The food processing industry is in some countries the largest manufacturing industry - much bigger than the alcohol or tobacco industries. The development of food processing technology has influenced agricultural production and the availability, distribution and consumption of foods more than any conscious nutrition education campaign. There is commonly too little fibre, too much fat and too much sugar in diets in many European countries, and there may be deficiencies in important micronutrients. Overeating of energy-rich foods leads to obesity - an important problem in many countries - which in turn is linked with cardiovascular diseases, diabetes, etc.

Other problems are more complex, arising from the interaction of learned eating habits, psychological conflicts and cultural values and stereotypes. Adolescent girls are particularly vulnerable to eating problems arising from the contradictory pressures of body-image stereotypes and the association of eating with happiness and gratification during a time of considerable psychological conflict and development.

Nonsmoking is the form of risk behaviour related to health that has been most studied. It has been estimated that up to 10 million people in the European Region are at risk of death from illnesses related to smoking between 1980 and the year 2000. Smoking-related diseases include lung cancer and some other cancers, ischaemic heart disease, chronic bronchitis, emphysema and certain chronic arterial diseases of the leg. Furthermore, the effects on the foetus of smoking by pregnant women are causing increasing concern.

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Source: https://www.industrydocuments.ucsf.edu/docs/tsjl0000

Meetings

From the most recent account of the Programme's Work (GRAY 1984) it seems that workshops, seminars & symposia are given the greatest priority as means of influencing decision-makers and potential activists. There have been a number of major symposia and anti-tobacco workshops:

Pre-1980	-	Cairo, Manila, London, Sao Paulo, Porto Alegre, Rio de Janeiro, Bombay
1980	-	Paris, Caracas, Uruguay, Buenos Aires
1981	-	Nagoya, New Delhi, Singapore, Budapest (3rd European), Kuwait (1st Gulf), Colombo
1982	-	Chile, Peru, Colombia, Manila
1983	-	Smoking Control Workshops - Bolivia, Colombia, Mexico, Pakistan, Bahrain (2nd Gulf Regional), Papua-New Guinea
1984	-	Workshops in Brazil, Ecuador, Panama, Paraguay, Khartoum, Jakarta, Buenos Aires, Warsaw.
1985	-	Kualar Lumpur
1986	-	Hong Kong

In addition, the Programme consultants are constantly making "site visits" (GRAY 1982) to make contacts, encourage the local workers, plan workshops, help in the formation of local anti-smoking movements etc. (GRAY 1984).

The World Conferences on Smoking & Health are obviously times of great activity. Summing up the Winnipeg event, Michael Daube said of UICC participation "Many speakers during the conference referred to the success of the UICC Programme which was itself the subject of a special workshop and a separate plenary paper, and a mobile exhibition which can be used at any future UICC workshop on smoking. Members of the UICC Programme team prominent in the Conference included David Nostbakken (Conference Chairman), Robert Wake (Programme Committee Chairman), and plenary speakers and session chairman included Nigel Gray, Kjell Bjartveit, Allan Erickson, Michael Kunze, Michael Wood, David Simpson and Mike Daube. All those concerned with the Programme were particularly encouraged to see the number of participants in the Conference from countries that have hosted UICC workshops: even more impressive was the amount of UICC-related activity taking place in meetings at and around the Conference." (DAUBE)

It would be natural for Smoking Control to feature in UICC meetings in general, and indeed there were a number of papers on tobacco given at the major conference in Seattle (September 1982) (see GRAY 1982). The next International Cancer Congress will be in Budapest, August 1986.

Publishing

The Union has issued a number of kits, brochures, displays, films and educational material (see UICC 1980), and integrates material on smoking in its other publications (see HOBBS as example). However, the three major monographs on smoking have all been issued in the 'Technical Report' series (see bibliography, GRAY and DAUBE, KUNZE, WAKE et al.)

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Source: https://www.industrydocuments.ucsf.edu/docs/tsjl0000

(2) measures to promote abstention from the use of tobacco so as to protect children and young people from becoming addicted;

(3) measures to ensure that a good example is set in all health-related premises and by all health personnel;

(4) measures leading to the progressive elimination of those socioeconomic, behavioural, and other incentives which maintain and promote the use of tobacco;

(5) prominent health warning which might include the statement that tobacco is addictive, on cigarette packets, and containers of all types of tobacco products;

(6) the establishment of programmes of education and public information on tobacco and health issues, including smoking cessation programmes, with active involvement of the health professions and the media;

(7) monitoring of trends in smoking and other forms of tobacco use, tobacco related diseases, and effectiveness of national smoking control action;

(8) the promotion of viable economic alternatives to tobacco production, trade and taxation;

(9) the establishment of a national focal point to stimulate, support, and coordinate all the above activites;

5. APPEALS to other organizations of the United Nations system:

(1) to support WHO in all ways possible within their fields of competence;

(2) to show solidarity with WHO's efforts to stem the spread of tobacco-induced diseases by protecting the health of non-smokers on their premises, as this action would have a major exemplar role;

(3) to help Member States in identifying and implementing economic alternatives to tobacco cultivation, production and trade;

6. REQUESTS the Director-General:

(1) to strengthen the present programme on smoking and health without waiting for its official introduction in the Eighth General Programme of Work, as a visible and resolute attitude by WHO would provide Member States with encouragement and support, which are necessary prerequisites to abating the smoking pandemic before the year 2000;

(2) to mobilize support for the present programme on smoking and health in terms of funds and manpower which would ensure adequate programme continuity on a long-term basis;

(3) to coordinate activities in support of WHO's action on smoking and health with other organizations of the United Nations system at the highest executive level;

(4) to continue and strengthen collaboration with nongovernmental organizations as appropriate;

(5) to ensure that WHO plays an effective global advocacy role in tobacco and health issues and that, in common with other health institutions, it plays an exemplar role in non-smoking practices;

(6) to provide support to national smoking control efforts;

(7) to report on progress to the Executive Board at its eighty-first session and to the Forty-first World Health Assembly.

Twelfth meeting, 15 January 1986
(EB77/SR/12)

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Integration with the other activities of the Organization

The WHO never loses an opportunity to mention tobacco when it is relevant to other parts of its work. In the context of the major campaign of 'Health for All by Year 2000' the European Regional Office conceives tobacco-smoking as a major obstacle, and this is echoed by the resolution of the Norwegian Medical Association urging their government to work for a smoke-free country (June 1981) which ended "The aim: a tobacco-free society by the year 2000 fits in well with the general target of the W.H.O. 'Health for All by the Year 2000'" (SVABØ). It is the European Office in Copenhagen which has carried out a series of surveys on smoking incidence; the current one is the fourth.

Another example of this integration of anti-smoking with other operations is the major survey of the 'present situation in prevention and control of lung cancer' (1982), of which the third paragraph began:-
"About 80-90% of all cases of lung cancer in developed countries are caused by tobacco - chiefly by the smoking of manufactured cigarettes."

The European Collaborative Trial in the Multifactorial Prevention of Coronary Heart Disease invariably includes smoking habits in the results from the various centres; thus the intervention in the study by KORNITZER included "health education promoting a cholesterol-lowering diet, smoking cessation, weight control, physical activity, and treatment of arterial hypertension".

Finally, in the series of annual 'World Health Days' the theme for 1980 was "Smoking or Health; the choice is yours" (see MAHLER).

Co-operation with other agencies & organization

As a specialised agency of the U.N., the WHO has considerable prestige on the international scene, as well as with its sister organisations of the U.N. itself. It was the Director-General who proposed that there should be no smoking at U.N. meetings (reported by ADAMS), and the exchange between WHO and FAO about tobacco-growing vs. allegations about the "Social Costs" of disease apparently led to some friction between the two agencies (LAND 1983, 1984) when the FAO issued its 'Economic Significance' booklet (1983), followed by the brief article in "Ceres" (March-April 1983), and despite the WHO using a right of reply ("Ceres" September/October 1984).

Other international bodies influenced by WHO include the European Parliament (the motion by DESOUCHES includes the preamble "Whereas ... the WHO and the Council of Europe have recommended a total ban on all advertising of tobacco products") and the EEC, with whom there was an exchange of letters in 1982 (RICHARD). Also included are the World Bank (ANON "International Agricultural Development" 1983), the International Air Transport Association and International Civil Aviation Organisation (a meeting on aircraft cabin air quality in 1983), and the organization of the World Cup (football) (Executive Board resolution 1982).

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Source: https://www.industrydocuments.ucsf.edu/docs/tsjl0000

Over the past 30 years, the general pattern of smoking has been changing considerably within the Region. There are indications that it may be levelling off in the Region as a whole, but there are still considerable differences between countries and between different subgroups within countries. In some countries, many people, especially members of high-status groups, have stopped smoking. In general, women and young children constitute groups whose risks are increasing. It is for this reason that the focus of smoking programmes within the Region has moved towards active nonsmoking as a positive form of health behaviour.

Despite the high long-term social and economic costs to society, tax policies have often made the sale of tobacco of short-term economic benefit to many governments. This fact, along with the powerful business interests involved, often counteracts directly or indirectly attempts by the health sector to reduce smoking. Little attention has been given to programmes of crop substitution or to the fundamental ethical question of whether it is right to produce a clearly pathogenic substance, even in countries with a state tobacco monopoly. These problems are further complicated by the cross-national promotion and distribution of tobacco and other products which affect health.

As regards good stress management, both the subjects just discussed are examples of behaviour that may be part of negative patterns of stress management. A growing body of research evidence demonstrates the consequences of stress-producing situations on both physical and mental health. Coping behaviour, then, has both direct (the frequency of stress reactions in the body) and indirect (tendency to use health-damaging forms of behaviour in attempts to feel better) effects on the preservation of health. Balanced physical activity, relaxation and social interaction, all of which promote health, are important components of effective coping. Unfortunately, the life situations of many people do not allow the balanced lifestyle most conducive to health.

Participation in healthy physical activity can be a very joyful experience and thus be an important factor in improving the quality of life. Physical fitness, acquired in youth and maintained throughout life, seems to be essential for the body to function healthily and at its best. Evidence suggests that improved fitness through regular physical activity helps in prevention and rehabilitation. It is especially important for elderly people to maintain patterns of regular physical activity in order to preserve functional capacity in old age.

Over the past decades, there has been a basic change in the way in which societies regard physical activity. Its contribution, not only to health but also to the general wellbeing of people, has been acknowledged.

Suggested solutions

Since advertising, the sale of consumer goods, TV shows, films, etc., are increasingly influencing basic values across national borders, efforts should be undertaken to see how Member States, with the cooperation of WHO and other organizations, can coordinate their individual campaigns so as to enhance the effectiveness of their health promotion policies and programmes. Action must be taken with regard to programming as well to ensure that programmes designed to promote healthy lifestyles recognize the importance of balance, satisfaction and support in the situations of life and respond to the special needs of the many people who are attempting to alter health-damaging habits.

In relation to smoking, strong, persistent nationally and internationally coordinated efforts are needed to change basic social attitudes and practices so that nonsmoking is established as the positive social norm, and considerable attention should be given to creating closer cooperation among Member States in this respect in the years ahead. Legislative steps, such as reducing the availability of tobacco to children, the labelling of all packages with a health warning, control of advertising of tobacco products, restrictions on smoking in public places, schools and workplaces, also play a very important role; duty-free sales of alcohol and tobacco should be abolished.

Since for some countries the growing of tobacco and the manufacture of cigarettes and other tobacco products are of short-term economic importance, initiatives should be taken in each Member State and at international level, to plan and gradually develop substitute crops and industries.

In relation to nutrition, it will be necessary to develop ways of ensuring the production and sale of healthy food products so that those most commonly eaten provide a well-balanced diet. A positive image of healthy eating should be developed with the cooperation of the media and popular public figures in school health education and with the support of industry and nongovernmental organizations, taking into account the cultural values and pressures linked to eating behaviour. Increased information about and support for mutual aid groups, such as those helping people cope with eating disorders, are needed.

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Source: https://www.industrydocuments.ucsf.edu/docs/tsjl0000

1.9 NON-COMMUNICABLE DISEASE PREVENTION AND CONTROL

Limitation of Smoking

EB45.R9 The Executive Board,

Welcoming the resolutions on the control of cigarette-smoking passed by the Directing Council of the Pan American Health Organization/Regional Committee for the Americas and the Regional Committee for Europe at their sessions held in 1969;

Recognizing that the individual must decide for himself whether he will risk endangering his health by smoking cigarettes, but should also have regard to the influence on others of his example; and

Believing that no organization devoted to the promotion of health can be neutral in this matter,

1. REQUESTS those attending its meetings to refrain from smoking in the room where such meetings are held; and

2. REQUESTS the Director-General to report to the Twenty-third World Health Assembly on measures which might be taken to affirm the Organization's view of the hazards of smoking and to demonstrate this by example at WHO meetings as well as to ensure that the Organization is able to assist Member States and interested health organizations to obtain information on these hazards.

Jan. 1970 181,7

WHA23.32 The Twenty-third World Health Assembly,

Having considered the report of the Director-General;

Recalling the resolutions on this subject adopted by the Executive Board, the Directing Council of the Pan American Health Organization/Regional Committee for the Americas, and the Regional Committee for Europe;

Conscious of the serious effects of smoking in promoting the development of pulmonary and cardiac disease, including bronchopulmonary cancer, chronic bronchitis, emphysema and ischaemic heart disease;

Being aware that bronchopulmonary cancer is at present increasing in all countries of the world where records are available in a form which permits assessment;

Holding that health agencies must now demonstrate their concern for the reduction of the main causal factor in diseases related to smoking; and

Considering that smoking of tobacco during meetings may constitute a nuisance to non-smokers,

RESOLVES that:

(1) all those present at meetings of the Assembly and its committees be requested to refrain from smoking in the rooms where such meetings are held;

(2) the Director-General be requested:

(*a*) to consider the desirability of making the subject for World Health Day "The health consequences of smoking," on the earliest possible occasion;

(*b*) to call the attention of all Members and Associate Members to the report on limitation of smoking and to suggest that the advantages of applying the recommendations on pages 19 and 20 of that report[1] should be considered in all countries;

(*c*) to consider convening an expert group to recommend further action that might be taken to discourage smoking;

(*d*) to examine to what extent and by what educational methods young people might be persuaded not to begin smoking;

(*e*) to bring to the attention of FAO the need for studying crop substitution in tobacco-producing countries;

(*f*) to report to the Executive Board at its forty-seventh session and to the Twenty-fourth World Health Assembly on the action proposed and the financial consequences for the Organization.

May 1970 184,15

EB47.R42 The Executive Board

1. THANKS the Director-General for his further report on the health consequences of smoking;

2. BELIEVES that a sustained effort by health and education authorities is needed to change the deeply ingrained habit of smoking in modern society and to prevent its extension, especially among young people; and

3. REQUESTS the Director-General:

(1) to continue to assemble information on the effects of smoking and the results of action taken to reduce the habit;

(2) to seek the assistance of the United Nations and the specialized agencies in promoting the social change required and in studying the economic consequences, actual and anticipated, of this change;

(3) to transmit the two reports he has prepared and resolution WHA23.32 to these agencies;

(4) to report further to the World Health Assembly.

Jan. 1971 189,24

WHA24.48 The Twenty-fourth World Health Assembly,

Having considered the report of the Director-General;

Recalling the resolutions on this subject adopted by the Twenty-third World Health Assembly, the Executive Board,[2] and the respective Regional Committees;

Recognizing the relationship between smoking and the development of pulmonary and cardiac disease, including lung cancer, ischaemic heart disease, chronic bronchitis and emphysema; and

Believing that a sustained effort by health and education authorities and others is needed to reduce tobacco smoking and to prevent the extension of the habit, with special attention to young people and pregnant women,

1. THANKS the Director-General for his report;

2. ENDORSES the recommendations contained therein;

3. CALLS UPON all Member States and Associate Members to give all possible consideration to putting these recommendations into effect; and

[1] See *WHO Chronicle*, 24, 365.

[2] Resolutions EB45.R9, WHA23.32 and EB47.R42 above

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Source: https://www.industrydocuments.ucsf.edu/docs/tsjl0000

(4) to give urgent consideration to having non-smoking as a theme for World Health Day as soon as possible, and in this and other ways to give maximum publicity to an anti-smoking campaign;

(5) to encourage research as to the causes of tobacco smoking;

(6) to report on progress in this field not later than the Thirty-third World Health Assembly.

May 1978 247, 41

WHA33.35[1] The Thirty-third World Health Assembly,

Recalling resolutions EB45.R9, WHA23.32, EB47.R42, WHA24.48, EB53.R31, WHA29.55, and WHA31.56 concerning the health hazards of tobacco smoking and WHO's role in the limitation of this harmful habit;

Noting the report of the WHO Expert Committee on Smoking Control;[2]

Reiterating its firm conviction that the effect of tobacco smoking is now a major public health problem in all industrialized countries and in many developing countries and that it will become so in the near future in all other developing countries unless action is taken now;

Mindful of the ill-effects of smoking, particularly on risk groups such as pregnant women, lactating mothers and children;

Seriously concerned about the aggressive promotional drives for the sale of cigarettes that occur in developing as well as developed countries, thus inducing the new generations to take up the habit of smoking;

Alarmed by the fact that advertising practices using psychological means in both industrialized and developing countries have the effect of inducing and perpetuating smoking habits, especially among youth;

Encouraged by the existence of total bans, restrictions or limitations on tobacco advertising in several countries;

Noting encouraging signs of expanded national activities and of increasing public awareness of the harmful health effects of cigarette smoking in many countries, partly as a result of WHO's efforts and of this year's World Health Day on "Smoking or health: the choice is yours";

Realizing that national and international strategies to combat the spreading of the habit of smoking must be carried out on a continuous, long-term basis;

Believing that WHO has an essential role to play in promoting effective smoking control policies;

1. URGES Member States:

(1) to strengthen, and to initiate where lacking, the smoking control strategies outlined in the above-mentioned resolutions, laying special emphasis on educational approaches, particularly with respect to youth, and on measures to ban, restrict or limit advertising of tobacco products;

(2) to support WHO's action in the field of smoking and health;

2. REQUESTS the Director-General:

(1) to further develop an effective WHO action programme on smoking and health, clearly defining lines of responsibility and priority areas, and taking into account the multidisciplinary and intersectoral character of the relationship between smoking and health;

(2) to ensure that WHO plays a leading role in coordinating international activities and to strengthen collaboration with other United Nations agencies and with relevant non-governmental organizations, and, particularly, to pursue the study on crop diversification in tobacco-growing areas in collaboration with FAO;

(3) to collaborate with Member States in their efforts to reduce smoking;

(4) to consider problems caused by the marketing and consumption of tobacco, particularly in developing countries;

(5) to mobilize financial and other resources for the implementation of the programme;

(6) to report on progress of this programme to the Thirty-fifth World Health Assembly.

May 1980 WHA33/1980/REC/1, 36

[1] See document WHA33/1980/REC/1, p. 128.
[2] WHO Technical Report Series, No. 636, 1979.

EB69.R18 The Executive Board,

Stressing the key role of cigarette smoking in the causation of lung cancer;

1. COMMENDS the Scottish association football team for its participation as a "non-smoking" team in the 1982 World Cup competition, thus setting an excellent example to all participants in sport and their supporters;

2. HOPES that other teams may wish to emulate this initiative;

3. REQUESTS the Director-General to take appropriate action to support this important health education opportunity in relation to the World Cup competition.

Jan. 1982 EB69/1982/REC/1, 16

REPORTS OF EXPERT COMMITTEES

	Published in *Technical Report Series* No.	Relevant resolution or decision
Smoking and its effects on health	568	EB57.R3 (1976)
Smoking control (Controlling the smoking epidemic)	636	EB60.R11 (1980)

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Source: https://www.industrydocuments.ucsf.edu/docs/tsjl0000

treatment of the rheumatic diseases as well as rehabilitation of those who suffer from them;

2. INVITES Member States to encourage programmes of research, prevention, early detection, treatment, rehabilitation and social welfare in regard to rheumatic diseases as well as information campaigns dealing with those diseases; and

3. REQUESTS the Director-General:

(1) to assist Member States with their programmes; and

(2) to report to the Twenty-ninth World Health Assembly on the progress made in this field.

May 1975 226, 32

WHA29.66 The Twenty-ninth World Health Assembly,

Having considered the Director-General's report on rheumatic diseases;

Taking into account the importance of such diseases as a cause of long-term disablement and their serious socioeconomic consequences;

1. IS OF THE OPINION that the prevention and control of rheumatic diseases should constitute an integral part of national health programmes, and that greater efforts are required to provide appropriate services within those programmes;

2. NOTES with satisfaction the work of the International League against Rheumatism in having 1977 designated as World Rheumatism Year, which will provide an opportunity for close cooperation between the various organizations concerned with the fight against rheumatic diseases;

3. RECOMMENDS that the World Health Organization should continue to assist governments, on their request, in promoting services for the prevention and control of rheumatic diseases, research in this field, and the training of rheumatologists.

May 1976 233, 42

Diabetes Mellitus

REPORTS OF THE EXPERT COMMITTEE ON DIABETES MELLITUS

	Published in *Technical Report Series* No.	Relevant decision
Second report	646	*EB67*(2) (1981)

1.16.19 CONTROL OF SMOKING

For previous resolutions, see Volume I, page 110.

See also under Education for Health, resolution WHA27.28, page 62 of this volume.

EB53.R31 The Executive Board,

Recalling resolutions WHA23.32 and WHA24.48 of the Twenty-third and Twenty-fourth World Health Assemblies;

Re-emphasizing the serious effects of smoking in promoting the development of such pulmonary and cardiac diseases as bronchopulmonary cancer, chronic bronchitis, emphysema and ischaemic heart disease and in aggravating the course of other diseases, to the detriment of the health and the economy of countries;

Considering that the study of the problem of tobacco smoking involves research, therapeutic, statistical, educational, legal, economic and other aspects needing periodic review and that it therefore requires a multidisciplinary approach;

Convinced that many countries would benefit from such study in dealing with the problem nationally,

REQUESTS the Director-General:

(1) to convene as soon as possible an expert committee to study the problem of tobacco smoking in all its aspects;

(2) to keep Member States and interested organizations informed of the results of studies in this field.

Jan. 1974 215, 25

WHA29.55 The Twenty-ninth World Health Assembly,

Recalling resolutions EB45.R9, WHA23.32, EB47.R42 and WHA24.48 concerning the health hazards of smoking and ways towards its limitation;

Noting with satisfaction that the recent WHO Expert Committee report on smoking and its effects on health,[1] prepared in accordance with resolution EB53.R31 and reviewed favourably by the Executive Board at its fifty-seventh session, provides a thorough and authoritative summary of current knowledge in the field and contains a number of important recommendations for WHO and the Member States;

Considering that the results of the Third World Conference on Smoking and Health, held in New York in June 1975, gave further support to the evidence and proposals presented by the WHO Expert Committee;

Recognizing the indisputable scientific evidence showing that tobacco smoking is a major cause of chronic bronchitis, emphysema and lung cancer as well as a major risk factor for myocardial infarction, certain pregnancy-related and neonatal disorders and a number of other serious health problems, and also has harmful effects on those who are involuntarily exposed to tobacco smoke;

Seriously concerned about the alarming worldwide trends in smoking-related mortality and morbidity and the rapidly increasing consumption of tobacco, especially in cigarettes, in countries in which it was not previously widespread, and about the growing number of young people and women who are now smoking;

Recognizing that an effective strategy to tackle the problem requires a concerted effort consisting of educational, restrictive and legislative measures, combined with coherent taxation and price policies, and supported by continuous research and evaluation on a multidisciplinary basis;

Noting that very few countries have thus far taken effective steps to combat smoking;

Believing that no organization devoted to the promotion of health can be indifferent in this matter, and that WHO has an important role to play in promoting effective policies against smoking, as envisaged in the Sixth General Programme of Work of WHO covering the period 1978-1983;

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Source: https://www.industrydocuments.ucsf.edu/docs/tsjl0000

1. URGES governments of Member States to identify the actual or anticipated health problems associated with smoking in their countries;

2. RECOMMENDS governments of Member States:

(1) to create and to develop effective machinery to coordinate and supervise programmes for control and prevention of smoking on a planned, continuous and long-term basis;

(2) to strengthen health education concerning smoking, as a part of general health education and through close collaboration with health and school authorities, mass media, voluntary organizations, employers' and employees' organizations and other relevant agencies, taking into account the different needs of various target groups, laying emphasis on the positive aspects of non-smoking, and supporting individuals wishing to stop smoking;

(3) to consider steps which can be taken towards ensuring that non-smokers receive protection, to which they are entitled, from an environment polluted by tobacco smoke;

(4) to give serious consideration to the legislative and other measures suggested by the WHO Expert Committee in its recent report on smoking and its effects on health;

3. REQUESTS the Director-General:

(1) to continue, and intensify, WHO's antismoking activities;

(2) to collate and disseminate information on smoking habits, smoking-related health problems and smoking control activities in Member States;

(3) to give assistance and encouragement to research in smoking and health, with particular emphasis on studies that are directly relevant to the assessment and improvement of the effectiveness of antismoking activities;

(4) to promote the standardization of:

(*a*) definitions, measurement methods and statistics concerning smoking behaviour, tobacco consumption and the occurrence of smoking-related morbidity and mortality;

(*b*) laboratory techniques used for the quantitative analysis of the harmful substances in tobacco products;

(5) to give assistance, upon request, to governments in the formulation, implementation and evaluation of their policies and programmes to combat smoking;

(6) to continue, in cooperation with the United Nations, the specialized agencies and appropriate nongovernmental organizations, to make all efforts deemed necessary to reduce smoking; and particularly to work out with the Food and Agriculture Organization of the United Nations and with the United Nations a joint strategy for crop-diversification in tobacco-growing areas with a view to avoiding the anticipated economic consequences of reducing tobacco consumption in the world as a whole for public health reasons;

(7) to convene an expert committee in 1977 or 1978 to review and evaluate the world situation in regard to smoking control;

(8) to report to a future Health Assembly on developments in this field.

May 1976 233, 35

[1] WHO Technical Report Series, No. 568, 1975

WHA31.56 The Thirty-first World Health Assembly,

Recalling resolutions EB45.R9, WHA23.32, EB47.R42, WHA24.48, EB53.R31 and WHA29.55 concerning the health hazards of tobacco smoking and ways towards its limitation;

Recognizing the increasing and indisputable scientific evidence showing that tobacco smoking is a major cause of chronic bronchitis, emphysema and lung cancer, as well as a major risk factor for myocardial infarction, certain pregnancy-related and neonatal disorders and a number of other serious health problems, and that it also has harmful effects on those who are involuntarily exposed to tobacco smoke;

Seriously concerned at the alarming increase in production and consumption of cigarettes during the last two decades in some of the countries, particularly developing countries, in which it was previously not widespread, and at the extensive promotional drive for the sale of cigarettes being carried out on radio and television, in newspapers and other news media, and through association with sporting and cultural events, often inducing young people to smoke tobacco;

Noting that few countries have so far taken comprehensive action to effectively combat smoking through educational, restrictive and legislative measures for the control of publicity and advertisements in the news media, combined with coherent taxation and price policies for tobacco cultivation and cigarette production;

Believing that WHO has an important role in promoting effective policies against smoking, as envisaged in the Sixth General Programme of Work covering the period 1978-1983 inclusive;

1. URGES Member States:

(1) to strengthen health education programmes concerning tobacco smoking as a part of general education, through close collaboration among health and education authorities and other relevant agencies, taking into account the different needs of the various target groups;

(2) to adopt comprehensive measures to control tobacco smoking, *inter alia* by providing for increased taxation on the sale of cigarettes and restricting as far as possible all forms of publicity for promotion of smoking;

(3) to protect the rights of non-smokers to enjoy an atmosphere unpolluted by tobacco smoke;

(4) to seek economically sound alternative undertakings to replace tobacco growing and processing, where appropriate;

2. REQUESTS the Director-General:

(1) to continue to intensify WHO's activities in connexion with control of tobacco smoking;

(2) to collaborate with Member States, the United Nations, the specialized agencies and appropriate nongovernmental organizations as required, in the formulation, implementation and evaluation of programmes to combat smoking, including studying possibilities for crop diversification in tobacco-growing areas;

(3) to cooperate with Member States upon request in developing measures for the control of publicity with regard to smoking through the news media, especially newspapers, radio and television;

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Appendix 2

WORLD HEALTH ORGANIZATION — ORGANISATION MONDIALE DE LA SANTE

Téléphone Central Exchange: 91 21 11 — Direct: 91 (followed by extension)

WHO HEADQUARTERS - STRUCTURE AND RESPONSIBLE OFFICERS
(as at 1 January 1985)

Offices of the Director-General	Tel. No.	
Director-General	2711/2981	DGO - Dr H. Mahler
Adviser on Health Policy	2739/2741	- Dr J. Cohen
Protocol and Governing Body Affairs	2776/2775	PGB - Mrs A.-M. Mutschler
Ombudsman	3506/3505	OMB - Mr J. K. Chang-Wailing
Eastern Mediterranean Special Programme	2705/2702	EMS - Dr G. E. Rifka
Health for all Strategy Coordination	2707/2764	HSC - Dr H. Hellberg
		Secretary, HFAWG
Global Programme Committee Secretariat	2739/2741	GPC - Secretary: Dr J. Cohen
Action Programme on Essential Drugs	3518/3529	DAP - Dr E. Lauridsen
Deputy Director-General	2716/2719	DDG - Dr T. A. Lambo
Emergency Relief Operations	2777/2778	ERO - Dr S. W. Gunn
Internal Audit	3277/3276	IAU - Mr J. H. Donald
Office of the Legal Counsel	2637/2638	LEG - Dr C.-H. Vignes
Office of Research Promotion and Development	2786/2787	RPD - Dr M. Abdelmoumène
Secretariat Committee on Research involving Human Subjects (SCRIHS)	3662/3641	SCR - Dr J. F. Dunne

Global Programmes based outside Headquarters		
Accidents Prevention	EURO 246/323	APR - Dr C. Romer
Health of the Elderly	EURO 356/327	HEE - Dr D. M. Macfadyen

Offices of the Assistant Directors-General		
Headquarters Programme Committee	2721/2724 2731/2732	HPC - Chairman: Dr J. Hamon Secretary: Mr A. Piel

Assistant Director-General and Chairman, Headquarters Programme Committee	2721/2724	ADG - Dr J. Hamon
Managerial Process for WHO Programme Development	2729/2727	MPW - Dr C. Chollat-Traquet
Division of Environmental Health	3582/3583	EHE - Dr B. H. Dieterich
Regional cooperation	3681/3594	- Mr M. A. Acheson
Environmental Hazards and Food Protection	3758/3791	EFP - Mr G. Ozolins
Food Safety	3760/3759	FOS - Dr F. K. Käferstein
Environmental Health in Rural and Urban Development and Housing	3580/3594	RUD - Mr R. E. Novick
International Programme on Chemical Safety	3588/3589	ICS - Dr M. Mercier
Food Toxicology	3569/3570	- Dr G. Vettorazzi
Environmental Health Technology and Support	3535/3536	ETS - Mr S. Unakul
Global Promotion and Cooperation for Water Supply and Sanitation	3546/3545	GWS - Mr O. A. Sperandio
Division of Epidemiological Surveillance and Health Situation and Trend	2388/2387	HST - Mr K. Uemura
Assessment	2847/2307	- Dr I. D. Carter
Development of Epidemiological and Health Statistical Services	2334/2843	DES - Dr K. Kupka
Epidemiological and Statistical Methodology	2378/2377	ESM -
Global Epidemiological Surveillance and Health Situation Assessment	2370/2371	GES - Dr H. E. Hansluvka
Division of Public Information and	2233/2228	IEH - Mr J. Ling
Education for Health	3129/3130	- Dr D. C. Johnson
Health Education Service	3129/3130	HED - Dr D. C. Johnson
Media Service (Press relations, Radio, TV)	2227/2929	MED - Mr G. L. T. Levi
Films	2289/2929	- Mme D. Hoffmann
Photo Library	2231/2829	- Mme J. Faundez
Visitors' service	2929/2226	- Mme M. Kernisan
Programme Support Service	2230/2244	PSS - Mr J. Bland
World Health Magazine	2230/2244	- Mr J. Bland

Assistant Director-General	Tel. No. 2511/2512	ADG - Dr D. Tejada-de-Rivero
Joint WHO/UNICEF Nutrition Support Programme, New York		- Dr P. L. Fazzi
Division of Family Health	3364/3365	FHE - Dr A. Petros-Barvazian
Maternal and Child Health	3359/3358	MCH - Dr M. Belsey
Nutrition	3320/3321	NUT - Dr A. Pradilla
Division of Health Manpower Development	2580/2551	HMD - Dr T. Fülöp
Information Service in the Programme of Health Manpower Development	2590	HMI - Miss F. Mawson
Educational Planning, Methodology and Evaluation	2505/2506	EPM - Dr J.-J. Guilbert
Fellowships	2508/2509	FEL - Dr A. Mejia
	2884	- Mme B. Amaro
Health Manpower Management	2554/2555	HMM - Dr V. Alexeev
Health Manpower Planning	2502/2593	HMP - Dr D. K. Ray
Health Manpower Research	2510/2880	HMR - Dr A. Segall
Health Manpower Systems	2508/2509	HMS - Dr A. Mejia
Health Team Development	2504/2501	HTD - Dr D. Flahault
Nursing	2507/2561	NUR - Dr A. Mangay-Maglacas
Division of Strengthening of Health Services	2520/2519	SHS - Dr E. Tarimo
Institutional Strengthening and Structuring of the Health Sector	2521/2518	IHS - Dr I. Tabibzadeh
Health Costs and Financing	2568/2883	HCF -
Monitoring Implementation and Effectiveness	2564/2563	MIE - Dr C. Montoya-Aguilar
Reorientation of National Health System	2562/2563	RNS -
Management and Organizational Effectiveness	2886/2563	MOE - Dr D. Smith
Logistics of Health Services	2569/2567	LHS - Dr N. Romanov
Technological Organization for Local Health Care	2526/2527	TLH - Dr F. Siem Tjam
Community Involvement for Health	2528/2547	CIH - Dr H. M. Kahssay
Intersectoral Action for Health	2523/2524	IAH - Dr A. El Bindari Hammad
Health Systems Research	2525/3224	HSR - Dr Y. Nuyens
Programme Information and Reporting	2566/2524	PIR - Mr E. Webster
Special Programme of Research, Development and Research Training in Human Reproduction	3371/3372	HRP - Dr J. Barzelatto
Managerial Process for National Health Development	2735/2733	MPN - Dr C. Vukmanovic

Assistant Director-General	2611/2615	ADG - Dr Lu Rushan
Division of Mental Health	3617/3618	MNH - Dr N. Sartorius
Alcohol-related Problems	3617/3618	- Dr N. Sartorius
Assessment and Monitoring	3622/3623	- Mr W. Gulbinat
Biological Psychiatry and Evaluation of Care	3621/3620	- Dr P. Morosov
Child Mental Health	3617/3618	- Dr N. Sartorius
Drug Dependence	3624/3625	- Dr A. Arif
Mental Health Service Development	3610/3611	- Dr J. Orley
Neurological Disorders	3605/3604	- Dr C. L. Bolis
Psychosocial Aspects of Health Care	3609/3608	- Dr A. Jablensky
Social and Epidemiological Aspects of Mental Health	3609/3608	- Dr A. Jablensky
UN Treaties concerning Psychotropic and Narcotic Drugs	3626/3625	- Dr I. Khan
Division of Noncommunicable Diseases	3471/3470	NCD - Dr V. J. Grabauskas
Diabetes	3443/3440	- Dr M. Mitrofanov
Rheumatic Diseases	3443/3440	- Dr M. Mitrofanov
Cancer	3477/3452	CAN - Dr J. Stjernswärd
Cardiovascular Diseases	3487/3486	CVD - Dr S. Dodu
Smoking and Health	3404/3403	SMO - Dr R. Masironi
Office of Occupational Health	3462/3461	OCH - Dr M. A. El Batawi
Oral Health	3451/3490	ORH - Dr D. E. Barmes

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4. REQUESTS the Director-General:

(i) to continue to assemble information on the health effects of tobacco smoking and the action being taken by countries to reduce the habit;

(ii) to place emphasis on the control and prevention of smoking as an integral part of operating programmes as and when feasible;

(iii) to continue in co-operation with the United Nations, the specialized agencies and the appropriate non-governmental organizations to foster a greater awareness of the health hazards of smoking and to take whatever action is deemed necessary to reduce them, and particularly to draw the attention of the Food and Agriculture Organization of the United Nations to the necessity of undertaking a study on crop diversification in tobacco-growing areas in view of the expected decrease in tobacco consumption;

(iv) to stimulate the strengthening of health education activities, including the production, dissemination and exchange of educational materials to discourage the habit of smoking; and

(v) to produce a code of practice that can guide governments in the formulation of legislative action relevant to the health consequences of smoking.

May 1971 193,25

PREVENTION OF BLINDNESS

WHA22.29 The Twenty-second World Health Assembly,

Recognizing that most of the world's blindness is preventable and that much of it is curable;

Noting the programmes on communicable eye diseases, especially trachoma and onchocerciasis, conducted by WHO, and the efforts which are being made by various governments to control these and other causes of blindness, including injuries and vitamin A deficiencies;

Noting also the increased activity in this field by non-governmental organizations concerned with blindness and its prevention and the recommendation of these organizations that there is need for the compilation and evaluation of more systematic information, clearer identification of practical objectives, and improved machinery for international co-ordination,

REQUESTS the Director-General:

(1) to undertake a study on the information which is at present available on the extent and all the causes of preventable and curable blindness and to propose activities in this field which the Organization would carry out within its programme of work; and

(2) to collaborate, as may be required, with other organizations having an interest in this domain, including certain non-governmental organizations in relation with WHO.

July 1969 176,12

WHA25.55 The Twenty-fifth World Health Assembly,

Recalling resolution WHA22.29 on the prevention of blindness adopted by the Twenty-second World Health Assembly;

Having considered the report of the Director-General on the prevention of blindness;

Being aware of the complexity of the problem and of the relatively limited information available on blindness and its causes throughout the world; and

Noting with interest the activities already undertaken by WHO in this field as well as the provision made for a study group on the prevention of blindness to be convened in 1972,

1. NOTES the report of the Director-General with appreciation;

2. REQUESTS the Director-General:

(1) to endeavour to obtain additional data on visual impairment and blindness and their prevention with special emphasis on the situation in developing countries, keeping in mind the need for a generally accepted definition of blindness and visual impairment;

(2) to promote further studies on the most efficient and economical means of preventing blindness, such studies to be carried out on an interdisciplinary basis in collaboration with other organizations active in this field;

(3) to assist Member States in educational programmes related to blindness and visual impairment, including those for the development of ophthalmological departments in medical schools;

(4) to intensify technical assistance to national programmes for the prevention of visual impairment and blindness, particularly in programmes against trachoma, onchocerciasis and xerophthalmia.

May 1972 201,28

1.9.1 CANCER

See also Health Statistics, resolution WHA2.38, sub-paragraphs (1) (c) and (5), page 171, resolutions EB4.R10, sub-paragraph (3), and WHA3.6, paragraph 4, page 172; and, under Coordination and External Relations, International Encouragement of Research into Cancer Control, pages 504-506.

1. General Programme

[WHA1.5] The First World Health Assembly gave number six priority to the study of cancer and entrusted it to the section on health statistics.

July 1948 13,310

EB17.R40 The Executive Board,

Recognizing the benefit to Members that may result from the creation of registry centres of pathologic tissues to serve internationally,

REQUESTS the Director-General to explore the possibility of WHO's organizing centres in several places in the world which would arrange for collection of human tissues and for their histopathological examination.

Jan. 1956 68,14

WHA10.18 The Tenth World Health Assembly,

Aware that cancer is a source of untold suffering to thousands of people, that it casts a shadow over many a home, and that its

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	Tel. No.	
Division of Diagnostic, Therapeutic and Rehabilitative Technology	3653/3654	DTR - Dr B. Sankaran
Biologicals	3890/3904	BLG -
Health Laboratory Technology	3646/3645	LAB - Dr L. Houang
Pharmaceuticals	3662/3663	PHA - Dr J. F. Dunne
Radiation Medicine	3652/3682	RAD - Dr N. T. Racoveanu
Rehabilitation	3656/3665	RHB - Dr J. Krol
Traditional Medicine	3639/3640	TRM - Dr C. O. Akerele
Programme of Essential Surgery	3653/3654	SRG - Dr B. Sankaran
Assistant Director-General	2411/2414	ADG - Dr S. K. Litvinov
Division of Communicable Diseases	2660/2661	CDS - Dr F. A. Assaad
Bacterial and Venereal Infections	2675/2674	BVI - Dr G. Causse
Leprosy	2683/2681	LEP - Dr S. K. Nordeen
Smallpox Eradication	2667/2666	SME - Dr I. Arita
Tuberculosis and Respiratory Infections	2690/2670	TRI - Dr A. Pio
Veterinary Public Health	2602/2603	VPH - Dr K. Bögel
Virus Diseases	2656/3284	VIR - Dr T. A. Bektimirov
Programme for the Prevention of Blindness	2697/2696	PBL - Dr B. Thylefors
Special Programme on Safety Measures in Microbiology	2622/2623	SMM - Mr V. R. Oviatt
Immunology	3488/3465	IMM - Dr G. Torrigiani
Diarrhoeal Diseases Control Programme	2632/2633	CDD - Dr M. H. Merson
Malaria Action Programme	3741/3781	MAP - Dr J. A. Najera-Morrondo
Epidemiological Methodology and Evaluation	3739/3782	EME - Dr E. Onori
Programming and Training	3744/3784	PAT - Dr P. F. Beales
Research and Technical Intelligence	3731/3783	RTI - Dr W. Wernsdorfer
Parasitic Diseases Programme	3872/3894	PDP - Dr A. Davis
Filarial Infections	3862/3898	FIL - Dr B. O. Duke
Schistosomiasis and other Snail-borne Trematode Infections	3874/3901	SCH - Dr K. E. Mott
Trypanosomiases and Leishmaniases	3870/3893	TRY - Dr P. de Raadt
Division of Vector Biology and Control	3845/3847	VBC - Dr N. G. Gratz
Ecology and Control of Vectors	3837/3838	ECV - Dr C. P. Pant
Equipment, Planning and Operations	3824/3896	EPO - Mr C. Kuo
Pesticide Development and Safe Use	3830/3829	PDS - Dr J. F. Copplestone
Expanded Programme on Immunization	2489/2869	EPI - Dr R. H. Henderson
Onchocerciasis Control Programme in the Volta River Basin (AFRO)	3882/3883	OCP - Mr J. D. M. Marr
Assistant Director-General	2578/2541	ADG - Dr F. Partow
Programme for External Coordination	2585/2584	COR - Mme I. Brüggemann
Health Resources Mobilization	2596/2581	HRM -
Collaboration with the United Nations System, Nongovernmental and other Organizations	2752/2754	CWU - Dr G. S. Mutalik
Food Aid Programmes	2761/2759	FAP -
Liaison Office with the UN, New York		LUN - Mrs V. M. Kalm
Liaison Office with Operational UN Agencies, New York		LNO - Dr K. Edström
Health and Biomedical Information Programme	2418/2419	HBI - Dr B. J. Cooper
Graphics	2357	GRA - Mr M. Magnin
Printing	2360/2358	PRT - Mr K. Wynn, Mr L. Valdes
Technical Terminology Service	2458	TER - Mr D. Lowe
Distribution and Sales	2476/3267	DSA - Mr M. Harriague
Documents	2341/2333	DOC - Mme M.-L. Tejada-de-Rivero
Office of Language Services	2854/2939	TRA - Mr E. Garcia-Monton
Arabic Translation	2392	- Mr M. G. Al-Hakim
Chinese Translation	3256	- Mr Wu Dashou
English Translation	2352	- Mr C. R. Stevenson
French Translation	2353	- Mr A. Zonco
Russian Translation	2859	-
Spanish Translation	2854	-

	Tel. No.	
Office of Library and Health Literature Services	2071/2068	HLT - Mrs B. Ruff
Office of Publications	2408/2403	PUB - Mr A. D. Loveday
Official Records	2451/2415	ORS - Mr D. H. Thompson
Periodicals	2421/2419	PRD - Mr J. Polling
Technical Publications	2406/2404	TPS - Dr G. C. Head
Health Legislation	2457/2402	HLE - Mr S. S. Fiasse
Division of Information Systems Support	2619/2618	ISS - Dr S. H. Mandil
Information Systems Methodology Team	2621/2617	ISM - Mr W. J. Towle
Administration & Finance Information Team and Data Base Administration	2447/2429	AFI - Mr C. Delmas
Epidemiology & Statistics Team	2432/2428	EST - Mr J. Bansal
Human Reproduction Programme Team	3306	HRT - Mr P. Diethelm
Technical Programme Information Support Team	2895/2617	TPI - Mr W. Trebeljahr
Text Processing Team	2433/2428	TXT - Mr D. N. Berg
Assistant Director-General	2311/2398	ADG - Mr W. W. Furth
Division of Personnel and General Services	2806/2807	PGS - Mr R. L. Munteanu
Staff Development and Training	2131/2818	SDT - Dr A. Robertson
Briefing	2120/2818	BRF - Ms F. Herzog
Conference and Office Services	2103/2104	COS - Mr N. Mani
Accommodation	2145/2104	ACM - Mr. M. Tomyska
Customs, Telephone Directory	2105/2104	CTD - Mme A.-M. Terrasson
Conference Services	3270/2192	CNF - Mrs K. Metwalli
Building Management	2153/3232	BDM -
Office Services	2101/2141	OSE - Mr B. J. Meijer
Documents Production Service	2102/3238	DPS - Mr P. J. M. Carvin
Records Management	2091/2023	REM - Mr A. Sayour
Joint Medical Service	3040	JMS - Dr J. Demé
Personnel	2122/2124	PER - Mr H. R. Crockett
Information Retrieval	2127/2178	RET - Mrs N. Carnazzola
Classification and Salary Administration	2916/2199	CSA - Mr P. Narayanan
Employment Policies and Administration	2130/3294	EPA - Mr R. Eggleston
Employment Policies	3279/3294	EMP - Mr F. Verzelloni
Contract Administration	2172/2173	ADM - Mlle B. Harley
Processing and Records	2174	PRR - Mme F. Hery
Selection and Recruitment	2164/2163	SRU - Mr P. Lässig
Manpower Resources	2168/2170	MPR - Dr N. Fetisov
General Services and Temporary Staff	2166/2165	GST - Mrs M. Prandle
Staff Management and Relations	2123/3293	REL - Mr R. Hubinois
Staff Counsellor	3231/3293	SCO - Dr M. Deichmann
Supply Services	2802/2801	SUP - Mr A. Nihlmar
Drugs and Biologicals Procurement	2139/2137	DBP - Dr T. Szuba
Environmental Supplies Procurement	2804/2805	ESP - Mr A. G. Beer
General Supplies Procurement	2185/2198	GSP - Mr G. A. Karastathis
Hospital and Teaching Equipment Procurement	2810	HTP - Mr A. Schmier
Laboratory Supplies Procurement	2811/2813	LSP - Mr J. E. Biles
Shipping Services	2181/3237	SHP - Mr P. Schnetzler
Administrative Management Services	2498/2426	MGT - Mr H. K. Larsen
Division of Budget and Finance	2825/2826	BFI - Mr A. M. Imbruglia
Budget	2824/2827	BUD - Mr C. Sandström
Accounts	2278/2293	ACT - Mr R. Marti
Insurance, Payroll and Claims	2831/2221	IPC - Mr J. Morgan
Claims Examination	2291/2837	CLX - Mr H. Torgler
Payroll	2838	PAY - Mr A. Pares
Insurance and Pensions	2270/2265	INS - Mr J. Duriez
Travel and Transportation	2222/2482	TAT - Mr J. Fournier
Treasury	2204/2217	TSY - Mr T. M. Mirza
Special Programme for Research and Training in Tropical Diseases	3802/3906	TDR - Dr A. O. Lucas
Research and Development	3804/3907	- Dr D. S. Rowe
Research Capability Strengthening	3815/3910	- Dr J. Barzelatto
Programme Management	3779/3778	- Dr R. Wilson

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